The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Testimony of The Commission on Women, Children, Seniors, Equity and Opportunity
Submitted to the Appropriations Committee
Friday, March 18, 2022 ~ 10:00 AM via Zoom

Co-Chairs Senator Osten and Representative Walker, Ranking Members Senator Miner and Representative France, and other distinguished members of the Appropriations Committee; we are submitting joint testimony written by Megan Malloy Yale School of Public Health; Megan Baker, Denise Drummond and Thomas Nuccio Policy Analysts CGA's Commission on Women, Children, Seniors, Equity, and Opportunity (CWCSEO). We are pleased to submit our testimony **in support** of the following bills:

- H.B. No. 5004 AN ACT CONCERNING FUNDING FOR BEHAVIORAL HEALTH MOBILE CRISIS INTERVENTION SERVICES FOR SCHOOL STUDENTS.
- H.B. No. 5433 (RAISED) AN ACT ESTABLISHING A COUNCIL ON MENTAL AND BEHAVIORAL HEALTH PROGRAM OVERSIGHT.
- S.B. No. 34 (COMM) AN ACT CONCERNING FUNDING FOR THE COVERED CONNECTICUT PROGRAM.

Background and Purpose of H.B. 5004

Mobile crisis centers are systems of care within the community that provide effective access to services and treatment for those in mental health crisis. The centers respond with trained clinicians with specialized training and knowledge to deal with people in situations of crisis.

In Connecticut the Child Health and Development Institute (CHDI), a program comprised of a team of nearly 150 trained mental health professionals across the state that respond immediately by phone or face-to-face within 45 minutes of when a child is experiencing an emotional or behavioral crisis. The purpose of the program is to serve children in their homes and communities, reduce the number of visits to hospital emergency rooms, and divert them from hospitalization if a lower level of care is a safe, effective alternative.[1]

In Support of H.B. 5004

Emergency rooms around the state are seeing upticks in children seeking mental health support services. "At Yale New Haven Children's Hospital's emergency department, 15% to 20% of its patient volume is related to behavioral health. In March, the pediatric emergency department at Yale New Haven Children's Hospital saw an average of 12 patients daily for behavioral health care. That increased to 26 children on any given day in the facility's 25-bed emergency department at the beginning of May…"[2] In order to reduce the number of children in these

[1] https://www.mobilecrisisempsct.org/about/
[2] Children with psychiatric needs are overwhelming emergency departments (ctmirror.org)

emergency rooms and provide them with the care they need we must fully fund day and nighttime mobile crisis intervention units throughout the state.

The Commission is encouraged to see the proposal to invest additional funding in emergency mobile crisis intervention units we believe will provide services for assessment, crisis management and diversion of children. We see these EMPS units are critical resources for families, schools, and hospitals.

We recommend the state to adopt a metric driven approach to measure the utilization and success of this program. As we know it many children who receive behavioral health care in emergency departments arrive via ambulance straight from their schools. In some of these instances children are not in need of emergency level care, but schools do not have the resources to properly diagnose the situation. We believe that additional funding allows for EMPS to provide faster response to crisis situations and diverts children away from emergency departments while placing them into the proper systems of emotional and behavioral support.

Background and Purpose of H.B. 5433

It is alarming that in 2019, in children between the ages of 12 and 17, suicide was the second leading cause of death. COVID-19 has only exacerbated this need, with over 20% of school-aged children reporting that their mental health has worsened since its start.[3] Along with increasing demand there are increasing disparities in access for children of color, with the burden falling largely on Black and Hispanic adolescents.[4] According to the Child Health and Development Institute of Connecticut, 65% of Black children and 62% of Latinx children with depression do not receive any treatment.[5]

We support the intent of H.B. 5433, which **establishes an oversight council to monitor and make recommendations to the Commissioner of the Department of Mental Health and Addiction Services concerning the planning and implementation of the delivery system for mental and behavioral health programs and services**.

The Commission would be honored to serve in some capacity on this oversight council either as a member or co-administrator, or in any necessary designated capacity.

In Support of H.B. 5433

[3] KFF | Mental Health and Substance Use State Fact Sheets
[4] KFF | Racial Disparities in COVID-19 Impacts and Vaccinations for Children
[5] Child Health and Development Institute of CT | Modernizing Outpatient Behavioral Health for Children

Section 1 subsection d identifies the numerous areas that the council shall monitor and make subsequent recommendations, one of which **being access to quality mental and behavioral health services and effective outreach**. The Commission supports this attention to increasing awareness to available services and how to access them as it recognizes the increasing need in this state; the persistence of the pandemic and its impact on people's overall quality of life "has translated into a 20% increase in calls to 2-1-1 from people seeking mental health treatment and more trips to the emergency department for children and adults who are in a mental health crisis."[6] Despite the increase in mental health service needs, "about 30% of adults in Connecticut suffering from anxiety and depression have not had their treatment needs met." [7] The Commission believes that the created council can provide key recommendations on how increase the access to quality mental health treatment services.

The Commission also supports the notion of having the council make recommendations regarding the **sufficiency of providers and provider rates**. The Kaiser Family Foundation reported increasingly large declines in pediatric care utilization, most likely due to providers suspending services or limiting capacities. [8] Long waiting lists for providers in-network, needing to travel long distances to in-network providers, and insufficient insurance coverage contributing to higher costs have all contributed to the barriers Connecticut families face in receiving much needed mental health care: "For out-of-network adult psychotherapy, prices increased from $123.30 in 2007 to 148.64 in 2017, a 20.6 percent increase."[9]

Out-of-network prices and cost-sharing for psychotherapy grew in the past decade. As there has been widening price differences between out-of-network and in-network care, patients are more like to only choose the limited in-network available options. Under the same overarching umbrella of increasing access to quality mental and behavioral health services, research regarding sufficiency of providers and provider rates can assist in making sure these services remain affordable and, ergo, accessible.

Furthermore, the Commission supports the explicit inclusion of council recommendations concerning the **linguistic and cultural competency of providers** within the bill text. Language access is vital in its ability to increase accessibility to a broader range of state residents. More notable is the additional call for the council to make recommendations surrounding service providers' cultural competency. Although translation services are effective for communicating on a foundational level, "the type of psychopathology, ethnicity and generational status, acculturation

[6] Prices and Cost-Sharing In-Network vs. Out-of-Network for Behavioral Health, 2007-2017 (nih.gov)
[7] Racial Disparities in COVID-19 Impacts and Vaccinations for Children | KFF
[8] Prices and Cost-Sharing In-Network vs. Out-of-Network for Behavioral Health, 2007-2017 (nih.gov)
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8128060/

and cultural background all appear to influence the manifestation of psychological distress." [10] Increased language access, when paired with cultural nuances, will not only ensure that more people can access these services, but that the quality and impact of said services will be significantly higher when they do.

Background and Purpose of S.B. 34

S.B. 34 expands low-to-moderate income families' access to the Covered Connecticut program. For residents making above the Medicaid eligibility limit of 138% of the federal poverty limit (FPL) for a single adult and 160% FPL for parents, this bill will increase access to the program to those with household incomes up to 300%.

Current coverage includes those between 160% and 175% FPL, translating to annual incomes between $20,000 to $22,500.[11] When individuals lose Medicaid eligibility either from a rise in income or a new job, they experience a significant increase in coverage costs and out-of-pocket fees. Despite only making up 13% of Connecticut's population, individuals with incomes between 100% and 199% FPL represent 26% of our uninsured residents. [12]For those making up to 399% of the FPL, 13.9% of residents ages 19 through 64 are uninsured. [13]The Connecticut Health Foundation put these numbers in context:

> "... a single individual with an income of 200% FPL earns $25,520 (before taxes) annually, or $2,127 monthly. If they faced an average premium and deductible costs for the benchmark plan (on the insurance exchange), approximately 22% of their annual income would be dedicated to health care."[14]

In Support of S.B. 34

Health insurance is directly tied to life expectancy. 8.3% of Connecticut residents ages 19 to 64 are uninsured.[15] These numbers are also exasperated along racial lines. While white individuals in this age group are uninsured at a rate of 4.8%, Black and Hispanic individuals are uninsured at rates of 7% and 14.4%, respectively.[16] These disparities are even visible when comparing rates neighborhood to neighborhood. Most Connecticut neighborhoods include a range of uninsured rates between 2% to 6%, yet many neighborhoods with majority compositions of Hispanics and Blacks face rates of 20% to even over 30% uninsured. [17] Several examples include:

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[10] https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/psychological-treatment
[11] Access Health CT 2022 Open Enrollment Toolkit
[12] https://www.cthealth.org/wp-content/uploads/2021/05/Uninsured-in-CT-fact-sheet-1.pdf
[13] Census - Table Results
[14] WA MATRIX 185 Brochure (cthealth.org)
[15] Census - Table Results
[16] Uninsured in CT fact sheet (cthealth.org)
[17] 10811_01_AHCT_Disparities_Report_V4.pdf (accesshealthct.com)

- The town of Redding is 98% white and has a 0% uninsured rate. The average life expectancy is 84.
- A Norwich neighborhood that is 43.7% nonwhite has a 12.8% uninsured rate. The average life expectancy is 71.
- A West Hartford neighborhood that is 83% white has a 0% uninsured rate. The average life expectancy is 83.
- A Hartford neighborhood that is 73.6% nonwhite has a 12.7% uninsured rate. The average life expectancy is 76.[18]

The largest disparity can be seen when comparing one of Connecticut's most affluent neighborhoods in Westport, which is 91% white, to a Northeast Hartford neighborhood, which is 94% Black and Hispanic. Those in Westport have an average life expectancy of 89, while those in Northeast Hartford have a 20-year difference in their life expectancy at 68.9 years. [19]The impacts of being uninsured contribute to Black Connecticut residents having the highest mortality in 6 of the 10 leading causes of death. [20]

Passing this bill will increase access to insurance and thus, healthcare. Vital healthcare including preventive care will alleviate the burden of untreated illness among those currently uninsured. At present, those who are above the Medicaid eligibility threshold, yet still making incomes that prevent them from affording coverage face huge barriers to care resulting in incredibly negative impacts to their health. An Access Health 2021 Report found that only when incomes above 400% of the FPL, roughly exceeding $50,000 to $75,000, do these barriers begin to disappear. [21]

It is our hope that this bill will remove these barriers by increasing access to the Covered Connecticut program to those with incomes up to 300% of the FPL. This would serve as an incredibly important step toward reducing the disparities in health faced by low-income families in Connecticut.

CWCSEO is a nonpartisan legislative agency within the Connecticut General Assembly with a data driven, cross-cultural approach to policy innovation, promoting best practices, breaking barriers, and helping to build a more equitable and accessible state for all Connecticut residents.

Thank you,

[18] Health Equity - Access Health CT
[19] 10811_01_AHCT_Disparities_Report_V4.pdf (accesshealthct.com)
[20] 10811_01_AHCT_Disparities_Report_V4.pdf (accesshealthct.com)
[21] 10811_01_AHCT_Disparities_Report_V4.pdf (accesshealthct.com)

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